CCHD DELAYED SCREEN REPORTING FORM

Utilize this form if the CCHD pulse oximetry screen was not completed **prior** to the submission of the newborn screening dried blood spot card.

Newborn Demographic Information:

First Name: _____ Last Name: _____

Birth Last Name: _____

DOB (mm/dd/yyyy): _____ Time of birth: _____

Sex: Male Female Indeterminate (Circle One)

Gestational age at birth (weeks): _____ Birth weight (grams): _____

Medical Record Number: _____

Mother Demographic Information:

First Name: _____ Last Name: _____

DOB (mm/dd/yyyy): _____

Address: _____

City: _____ State: _____ Zip: _____

Delayed Screening Information:

Date of initial pulse ox screening for CCHD: _____ Military Time: _____

If not performed, indicate the reason: (required field)

Refused	On O2	Other _____
Expired	Transferred	_____

Echocardiogram performed?

Yes No Unsure

Final Result of the CCHD Screen:

❑ Pass (Negative) ❑ Fail (Positive)

Person completing form: _____

Print Name

Title: _____ **Date Completed:** _____

Phone Number: _____ **Facility Name:** _____